

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 07/17)

Fiscal Year 2018-19	Business Unit 5225	Department California Department of Corrections and Rehabilitation	Priority No. 1
Budget Request Name 5225-131-BCP-2018-GB		Program VARIOUS	Subprogram VARIOUS

Budget Request Description
Mental Health Bed Management

Budget Request Summary

The California Department of Corrections and Rehabilitation requests \$20.1 million General Fund and 115.9 positions in 2018-19 and ongoing to address mental health treatment bed capacity, improve health care data reporting, and manage patient referrals.

Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Code Section(s) to be Added/Amended/Repealed	
Does this BCP contain information technology (IT) components? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, departmental Chief Information Officer must sign.</i>	Department CIO	Date

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Project Approval Document: Approval Date:

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By Doug Chatfield	Date	Reviewed By Chris Helton	Date
Department Director Diana Toche	Date	Agency Secretary Scott Kernan	Date

Department of Finance Use Only

Additional Review: ☐ Capital Outlay ☐ ITCU ☐ FSCU ☐ OSAE ☐ CALSTARS ☐ Dept. of Technology

PPBA	Original Signed By Emma Jungwirth	Date submitted to the Legislature 1/10/2018
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BCP Fiscal Detail Sheet

BCP Title: Mental Health Bed Management

BR Name: 5225-131-BCP-2018-GB

Budget Request Summary

	FY18					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	115.9	115.9	115.9	115.9	115.9
Total Positions	0.0	115.9	115.9	115.9	115.9	115.9
Salaries and Wages						
Earnings - Permanent	0	12,558	12,558	12,558	12,558	12,558
Total Salaries and Wages	\$0	\$12,558	\$12,558	\$12,558	\$12,558	\$12,558
Total Staff Benefits	0	5,803	5,803	5,803	5,803	5,803
Total Personal Services	\$0	\$18,361	\$18,361	\$18,361	\$18,361	\$18,361
Operating Expenses and Equipment						
5301 - General Expense	0	152	152	152	152	152
5302 - Printing	0	18	18	18	18	18
5304 - Communications	0	30	30	30	30	30
5306 - Postage	0	8	8	8	8	8
5320 - Travel: In-State	0	56	56	56	56	56
5322 - Training	0	19	19	19	19	19
5324 - Facilities Operation	0	1,136	1,136	1,136	1,136	1,136
5340 - Consulting and Professional Services - Interdepartmental	0	6	6	6	6	6
5340 - Consulting and Professional Services - External	0	-50	-109	-109	-109	-109
5368 - Non-Capital Asset Purchases - Equipment	0	343	209	209	209	209
539X - Other	0	3	3	3	3	3
Total Operating Expenses and Equipment	\$0	\$1,721	\$1,528	\$1,528	\$1,528	\$1,528
Total Budget Request	\$0	\$20,082	\$19,889	\$19,889	\$19,889	\$19,889
Fund Summary						
Fund Source - State Operations						
0001 - General Fund	0	20,082	19,889	19,889	19,889	19,889
Total State Operations Expenditures	\$0	\$20,082	\$19,889	\$19,889	\$19,889	\$19,889
Total All Funds	\$0	\$20,082	\$19,889	\$19,889	\$19,889	\$19,889

Program Summary

Program Funding

4661 - Psychiatric Program-Adult	0	5,660	5,611	5,611	5,611	5,611
4670 - Dental and Mental Health Services Administration-Adult	0	2,441	2,412	2,412	2,412	2,412
4500059 - Office of Research	0	1,190	1,172	1,172	1,172	1,172
4530010 - General Security	0	3,079	3,079	3,079	3,079	3,079
4540032 - Facility Operations	0	1,136	1,136	1,136	1,136	1,136
4540040 - Classification Services	0	995	987	987	987	987
4650014 - Medical Other-Adult	0	3,105	3,098	3,098	3,098	3,098
4660014 - Mental Health Other-Adult	0	2,476	2,394	2,394	2,394	2,394
Total All Programs	\$0	\$20,082	\$19,889	\$19,889	\$19,889	\$19,889

Personal Services Details

Positions	Salary Information			<u>CY</u>	<u>BY</u>	<u>BY+1</u>	<u>BY+2</u>	<u>BY+3</u>	<u>BY+4</u>
	Min	Mid	Max						
1139 - Office Techn (Typing) (Eff. 07-01-2018)				0.0	8.2	8.2	8.2	8.2	8.2
1312 - Staff Info Sys Analyst (Spec) (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
1583 - Sr Programmer Analyst (Spec) (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
5731 - Research Analyst II (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
5737 - Research Mgr II (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
5742 - Research Program Spec I (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
5758 - Research Program Spec II (Eff. 07-01-2018)				0.0	2.0	2.0	2.0	2.0	2.0
7860 - Research Spec II -Various Studies (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
8252 - Sr Psych Techn (Safety) (Eff. 07-01-2018)				0.0	0.8	0.8	0.8	0.8	0.8
8253 - Psych Techn (Safety) (Eff. 07-01-2018)				0.0	8.4	8.4	8.4	8.4	8.4
8257 - Licensed Vocational Nurse (Eff. 07-01-2018)				0.0	1.3	1.3	1.3	1.3	1.3
8336 - Hlth Program Spec II (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
8338 - Hlth Program Spec I (Eff. 07-01-2018)				0.0	2.0	2.0	2.0	2.0	2.0
9275 - Registered Nurse - CF (Eff. 07-01-2018)				0.0	12.0	12.0	12.0	12.0	12.0
9283 - Psychologist-Clinical - CF (Eff. 07-01-2018)				0.0	14.1	14.1	14.1	14.1	14.1
9286 - Recr Therapist - CF (Eff. 07-01-2018)				0.0	7.7	7.7	7.7	7.7	7.7
9288 - Sr Psychologist - CF (Supvr) (Eff. 07-01-2018)				0.0	6.3	6.3	6.3	6.3	6.3
9318 - Supvng Registered Nurse II - CF (Eff. 07-01-2018)				0.0	1.0	1.0	1.0	1.0	1.0
9659 - Corr Sgt (Eff. 07-01-2018)				0.0	0.5	0.5	0.5	0.5	0.5
9662 - Corr Officer (Eff. 07-01-2018)				0.0	21.8	21.8	21.8	21.8	21.8
9758 - Staff Psychiatrist (Safety) (Eff. 07-01-2018)				0.0	10.4	10.4	10.4	10.4	10.4

9761	-	Sr Psychiatrist (Supvr) (Safety) (Eff. 07-01-2018)	0.0	0.4	0.4	0.4	0.4	0.4
9859	-	Chief Psychologist - CF (Eff. 07-01-2018)	0.0	1.0	1.0	1.0	1.0	1.0
9902	-	Corr Counselor III (Eff. 07-01-2018)	0.0	7.0	7.0	7.0	7.0	7.0
9904	-	Corr Counselor I (Eff. 07-01-2018)	0.0	4.0	4.0	4.0	4.0	4.0

Total Positions

0.0 115.9 115.9 115.9 115.9 115.9

Salaries and Wages			CY	BY	BY+1	BY+2	BY+3	BY+4
1139	-	Office Techn (Typing) (Eff. 07-01-2018)	0	323	323	323	323	323
1312	-	Staff Info Sys Analyst (Spec) (Eff. 07-01-2018)	0	76	76	76	76	76
1583	-	Sr Programmer Analyst (Spec) (Eff. 07-01-2018)	0	84	84	84	84	84
5731	-	Research Analyst II (Eff. 07-01-2018)	0	68	68	68	68	68
5737	-	Research Mgr II (Eff. 07-01-2018)	0	84	84	84	84	84
5742	-	Research Program Spec I (Eff. 07-01-2018)	0	71	71	71	71	71
5758	-	Research Program Spec II (Eff. 07-01-2018)	0	159	159	159	159	159
7860	-	Research Spec II -Various Studies (Eff. 07-01-2018)	0	86	86	86	86	86
8252	-	Sr Psych Techn (Safety) (Eff. 07-01-2018)	0	60	60	60	60	60
8253	-	Psych Techn (Safety) (Eff. 07-01-2018)	0	565	565	565	565	565
8257	-	Licensed Vocational Nurse (Eff. 07-01-2018)	0	83	83	83	83	83
8336	-	Hlth Program Spec II (Eff. 07-01-2018)	0	78	78	78	78	78
8338	-	Hlth Program Spec I (Eff. 07-01-2018)	0	142	142	142	142	142
9275	-	Registered Nurse - CF (Eff. 07-01-2018)	0	1,330	1,330	1,330	1,330	1,330
9283	-	Psychologist-Clinical - CF (Eff. 07-01-2018)	0	1,660	1,660	1,660	1,660	1,660
9286	-	Recr Therapist - CF (Eff. 07-01-2018)	0	630	630	630	630	630
9288	-	Sr Psychologist - CF (Supvr) (Eff. 07-01-2018)	0	811	811	811	811	811
9318	-	Supvng Registered Nurse II - CF (Eff. 07-01-2018)	0	125	125	125	125	125
9659	-	Corr Sgt (Eff. 07-01-2018)	0	46	46	46	46	46

9662 - Corr Officer (Eff. 07-01-2018)	0	1,723	1,723	1,723	1,723	1,723
9758 - Staff Psychiatrist (Safety) (Eff. 07-01-2018)	0	2,942	2,942	2,942	2,942	2,942
9761 - Sr Psychiatrist (Supvr) (Safety) (Eff. 07-01-2018)	0	119	119	119	119	119
9859 - Chief Psychologist - CF (Eff. 07-01-2018)	0	158	158	158	158	158
9902 - Corr Counselor III (Eff. 07-01-2018)	0	779	779	779	779	779
9904 - Corr Counselor I (Eff. 07-01-2018)	0	356	356	356	356	356
Total Salaries and Wages	\$0	\$12,558	\$12,558	\$12,558	\$12,558	\$12,558
Staff Benefits						
5150450 - Medicare Taxation	0	182	182	182	182	182
5150500 - OASDI	0	73	73	73	73	73
5150600 - Retirement - General	0	3,270	3,270	3,270	3,270	3,270
5150800 - Workers' Compensation	0	500	500	500	500	500
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	147	147	147	147	147
5150900 - Staff Benefits - Other	0	1,631	1,631	1,631	1,631	1,631
Total Staff Benefits	\$0	\$5,803	\$5,803	\$5,803	\$5,803	\$5,803
Total Personal Services	\$0	\$18,361	\$18,361	\$18,361	\$18,361	\$18,361

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A. Budget Request Summary

The California Department of Corrections and Rehabilitation (CDCR) requests \$20.1 million General Fund and 115.9 positions in 2018-19 and ongoing to address mental health treatment bed capacity, improve health care data reporting, and manage patient referrals.

B. Background/History

CDCR and the California Correctional Health Care Services (CCHCS) are required by the 2009 Mental Health Program Guide ordered by the District Court as part of the *Coleman v. Brown* class action lawsuit, to provide each patient with the proper level of care at the appropriate custody level in a timely manner. This means responding to emerging mental health issues and transferring patients to inpatient and Mental Health Crisis Beds (MCHBs) within Program Guide timelines. According to the Program Guide, the conditions of patients assigned to specialized housing are to be reviewed to make sure they continue to be housed in the proper level of housing; that length of stay guidelines are maintained; that there is appropriate staffing at each level of housing available; and that patient population and movement are carefully tracked. Properly transferring patients also requires there to be a sufficient number of beds available at the different levels of care.

Patient Referral Process

The patient referral process is outlined below for both Intermediate and Acute Inpatient Programs and MCHBs.

Referrals to Intermediate and Acute Inpatient Programs

- Patients suffering an impairment of functioning with signs and symptoms that may be attributed to an acute major mental disorder or an acute exacerbation of a chronic major mental illness and require a short-term intensive-treatment program shall be referred to the Acute level of care.
- Patients with serious mental disorders that require longer-term mental health intermediate and non-acute inpatient treatment are referred to an Intermediate Care Facility (ICF).

Once a referral is made and accepted to an inpatient program, the patient is required to be transferred within ten days for the Acute level of care and within 30 days for the ICF level of care.

CDCR has developed processes that focus on housing patients at their least restrictive custodial housing levels to address the historical waitlist issues that occur at the Acute and single-cell ICF levels of care. More recently, additional measures have been implemented in an attempt to reduce delays to meet transfer timelines and prevent the inpatient waitlists. These measures include the activation of 70 ICF multi-cell beds at California Medical Facility for additional capacity, and assuming responsibility for the three psychiatric inpatient programs within CDCR institutions (Salinas Valley State Prison Psychiatric Program, California Medical Facility Psychiatric Program, and the California Health Care Facility Psychiatric Program) on July 1, 2017. However, patients have continued to be placed on waitlists. On April 19, 2017, the District Court ordered that beginning May 15, 2017, monetary sanctions in the amount of \$1,000 per day be applied for every patient whose placement exceeded timelines for placement into the Acute and ICF levels of care (Attachment A - *Coleman* Court Order, April 19, 2017).

Referrals to Mental Health Crisis Beds

- A patient suffering from an acute, serious mental disorder resulting in serious functional disabilities, or who is dangerous to self or others, shall be referred to a MCHB. Once the referral is made by a mental health clinician, the patient is required to be transferred to a MCHB within 24 hours.

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On January 23, 2017, the District Court conducted a hearing regarding the timely placement of patients into an inpatient facility and MHCBs. Based on this hearing, the Court issued an order on April 19, 2017, in which it contemplated the insufficient number of MHCBs and noted that other factors were necessary to “eliminate transfer delays. These factors include: proper triaging of the need for crisis beds; quality improvement practices that, among other things, discharge patients from crisis beds early to free up the beds for inmates in need of the beds; and efforts to minimize the number of referrals that are quickly rescinded.” Although the District Court has allowed additional time for CDCR to work on measures to comply with the transfer timeline, the April 19, 2017 order called for assessing sanctions for any patient that is not placed in a MHCB within Program Guide timelines.

Mental Health performance data shows that from September 1, 2016, to February 28, 2017, MHCB transfers occurred within 24 hours only 62 percent of the time. Based on this low compliance rate, various initiatives were proposed, implemented, and reported to the District Court. These efforts included the activation of a Dialectical Behavior Therapy program; various trainings for clinicians focused on case formulation, MHCB triaging, and treatment planning; and clustering of MHCB transfers by region. As a result of these initiatives, performance data during the period of January 2017 through June 2017, indicates MHCB transfers occurred within the 24 hour timeframe 68 percent of the time, which reflects a slight improvement, but not compliance.

Inpatient monitoring, bed tracking, and referral management are of the utmost importance for CDCR to adhere to Program Guide transfer timelines. Also important is having a sufficient number mental health crisis beds available and that these beds are geographically accessible to affect timely transfers of patients.

The Federal Court has ruled that it will fine CDCR \$1,000 per day for every patient who is not moved to the appropriate level of care within mandated timeframes. These sanctions are being accrued, but the Court has not billed CDCR for the fines to date. This request addresses these issues.

Workload History by Calendar Year

Workload Measure	2012	2013	2014	2015	2016	2017 (through June)
New Acute Referrals	689	796	1,108	1,287	1,649	803
New Intermediate Referrals	1,002	1,137	1,295	1,064	1,107	471
Internal Transfers (within Psychiatric Inpatients/Department of State Hospitals)	Unknown – Tracked by DSH				1,095	541
Average Inpatient Program Pending List (tracked by CDCR beginning in 2015)	Unknown – Tracked by DSH				215	153
MHCB Referrals	3,584	5,062	8,606	12,603	15,269	7,262
Average MHCB Pending List	4	12	29	26	67	39
Average Ad Hoc Data Requests	4-6 requests/month			4-6 requests/week		4-6 requests/day

C. State Level Considerations

CDCR and CCHCS must implement new policies and enhance current processes to ensure compliance with inpatient and MHCB transfer timelines consistent with the Program Guide and the April 19, 2017 court order to avoid further monetary sanctions imposed by the Court.

D. Justification

CDCR and CCHCS recognize the need to allocate resources to institutions and headquarters to enhance the current staffing authority to address historical waitlist issues in the ongoing litigation related to the *Coleman* case, and to avoid future monetary sanctions by the Court. CDCR and CCHCS requests resources to implement monitoring and quality improvements as well as create additional bed space that will allow the

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Department to meet inpatient and MHCb transfer timelines, provide clinical reviews of referrals and LRH designations, and provide timely transfers of patients to inpatient programs and reduce lengths of stay in MHCb.

To address these issues, CCHCS is taking a multi-pronged approach that includes:

- Implementing an Inpatient Reporting Unit (IRU).
- Increasing staff for the Health Care Placement and Oversight Program (HCPOP).
- Realigning a MHCb unit from California State Prison – Sacramento to Richard J. Donovan Correctional Facility.
- Creating “flex beds” at California Institution for Women, California Health Care Facility, and CMF.
- Moving the Mental Health population projections to the Office of Research.

Inpatient Reporting Unit

These resources will be used to monitor and report patient movement to ensure timely transfers; implement bed utilization management oversight; and perform housing reviews to enhance efforts to comply with the inpatient and MHCb transfer timelines and alleviate ongoing monetary sanctions imposed by the District Court. The IRU will address the LRH and lengths of stay issues within the system.

Currently, housing reviews are only conducted locally. Historical and current data reflect a consistent surplus and availability of beds in the unlocked dorm setting, which is the LRH designation possible. That same data also identifies waitlists occurring at the Acute and single cell ICF level of care beds. As patients make progress toward their treatment goals and are able to be moved to their LRH, beds at the Acute and single cell ICF levels of care become available. CDCR is proposing to implement regular clinical reviews by headquarters staff to provide the oversight and ensure that patients are being moved to their LRH when clinically appropriate.

Using two limited-term clinical staff, CDCR activated the IRU on July 1, 2017. The IRU is responsible for monitoring and reporting patient movement to ensure timely transfers to inpatient facilities, including ICF, Acute, and MHCb. The IRU performs housing and utilization reviews, which ensure that patients in the Acute and ICF programs are receiving treatment in their LRH at the time of the referral and ongoing. At the time a patient is referred to an inpatient level of care, HCPOP determines the patient's LRH based on custodial factors. At the time the inpatient facility receives the referral, a housing review is conducted based on clinical factors. The treatment team is required to review the ongoing clinical factors, progress of their treatment, and appropriateness of the patient to be moved to their LRH environment. Housing reviews also enhance efforts to comply with inpatient and MHCb transfer timelines and prevent monetary sanctions being imposed by the District Court.

Before the establishment of the IRU, housing reviews based on clinical factors were conducted at the local level, and patients were frequently placed into more restrictive housing than they required. In the IRU, specially trained clinicians who understand the patients LRH bed needs determine which patients have clinical factors that require more restrictive housing, which has led to the ability to fully utilize inpatient beds in LRH. In addition, for patients housed in more restrictive environments, the IRU reviews the local treatment team's justification for continuing this level of housing to ensure that it is sound, and if not, that patients are moved to their LRH as soon as possible, based on clinical factors. IRU also reviews patients with multiple admissions, and those with long lengths of stay, to ensure that the inpatient beds are used efficiently and effectively.

The IRU includes specially trained psychologists who perform clinical reviews to ensure patients are placed in the appropriate level of mental health care and housing. Since September 13, 2017, substantially due to the efforts of the IRU, all patients (approximately 225 to 275 patients per month) have transferred to inpatient Acute or ICF Care Programs within transfer timelines. The Chief Psychologist and Sr. Psychologist, Specialist currently working in this unit were hired into limited-term positions due to critical need, and the unit will cease to function without the additional staff and permanent funding approval.

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An additional role of the team within the IRU is to provide headquarters clinical oversight of MHCB bed utilization. Current policy per the Mental Health Program Guide, states that patients may be admitted to a MHCB for up to ten days. The purpose of an MHCB is to treat and stabilize a patient to be able to return to an outpatient setting, or if the patient needs ongoing inpatient treatment, to be referred to an Acute or ICF level of care. Data shows that there are a number of institutions that have an average MHCB Length of Stay (LOS) beyond the ten day policy, which results in a waitlist of patients waiting to be transferred to a MHCB (See Attachment B – MCHB Average Length of Stay.) Institutions are required to provide justification and obtain approval of the MHCB Chief Psychiatrist, or designee, when keeping a patient beyond the ten days. Having a sufficient number of IRU staff to perform clinical reviews will ensure that patients are discharged timely, which will help to eliminate a MHCB waitlist, improve utilization of existing inpatient beds, and will allow the Department to avoid or reduce monetary sanctions threatened by the Court.

The IRU staffing request (6.0 positions) is as follows:

- 1.0 Chief Psychologist
- 5.0 Senior Psychologist, Specialist

HCPOP

HCPOP is responsible for tracking and reporting patient movement. HCPOP's mission includes bed management, developing and managing data systems, coordinating patient placements in outpatient levels of care, analyzing and projecting mental health bed needs, and interpreting and developing policy. These duties are in addition to health care transfer endorsements, and to HCPOP Operations Unit's other areas of responsibility, which are detailed below:

- Data Management and Reporting - HCPOP is the data repository for bed management and tracking timely access to care for CCHCS. HCPOP Operations currently produces and distributes more than 50 regular reports for various internal and external stakeholders, including the CDCR Secretary and undersecretaries, the federal Receivership, and the *Coleman* Court. (See Attachment C – HCPOP Description of Distributed Reports.)
- Transportation Scheduling Coordination – HCPOP serves as the liaison between the Statewide Mental Health Program and the Statewide Transportation Unit. HCPOP's Operations Unit monitors all institutions' Correctional Clinical Case Management System and Enhanced Outpatient Program intake to ensure patients arrive in manageable numbers and within court-ordered transfer timeframes.
- Bed Planning – HCPOP Operations is deeply involved in the bed planning activities for CCHCS and CDCR. In 2008, the role was limited to compiling mental health population data on a monthly basis to provide to an outside consultant who independently analyzed the data and produced a bed need projection study for the Department. Beginning in 2011, as a result of various population reduction initiatives and the availability of improved data sources, HCPOP Operations staff began, on a weekly basis, to complete many more of the essential data collections, data validations, and auditing required to develop the forecasts. In 2014, the Court instructed CDCR to assume primary responsibility for developing the projections process while continuing to work with the court-approved consultant.

HCPOP Operations Unit staff are responsible for validating, maintaining, and updating the HCPOP Portal systems. This currently includes Referrals to Inpatient Programs Application (RIPA) and HCPOP Endorsements and Referrals Tracking Application (HEART) data systems. To ensure the integrity of the data used to produce essential reports, HCPOP staff must:

- Manage RIPA updates:
 - Monitor and research daily patient movement within, admission to, discharge from, and bed status for 1,647 Acute and Intermediate program beds statewide.
 - Monitor the status of an average of 300 referrals each month and 150 pending cases on a daily basis (based on January-June 2017 data) from treatment team referral and level of care determination to endorsement and admission to the inpatient program.

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- Monitor and record in detail any pertinent information that may delay the transfer of a patient to an inpatient treatment program within mandated Program Guide transfer timeframes.
- Manage HEART updates:
 - Monitor and research daily patient movement within, admission to, discharge from, and bed status for 449 MHCBS statewide.
 - Monitor the status of, on average, 1,210 referrals each month and 40 pending cases on a daily basis (based on January-June 2017 data).
- Develop and apply continuous validation protocols critical to monitoring and improving data system accuracy, including but not limited to:
 - Verifying the accuracy of data inputs against other data sources.
 - Identifying and researching any potential errors in reports or data inputs.
 - Performing regular and consistent system-to-system checks and comparisons to identify potential bugs, reporting errors, and erroneous data.
 - Documenting data collection and reporting processes to clearly delineate instructions that ensure data quality, accuracy, and integrity.

HCPOP staff must also work with CCHCS Information Technology to complete the development of HEART to track Specialized Medical Beds and other placement referrals; to develop new systems as needed; and to more rapidly update, test, and release future versions to align existing systems with changes to policies and procedures impacting business requirements and systems performance. Moreover, the staff will be responsible for activities and tasks required to facilitate effective health care bed management, such as coordination of outpatient transportation scheduling and bed inventory maintenance.

Due to the *Coleman* Court's mandates and the Special Master's expressed intent to oversee and monitor the implementation of all new policies, the number of ad hoc requests for data increased dramatically and is expected to continue to increase. For instance, the number of ad hoc reports being requested from outside entities has increased from 4 to 6 per month in 2012-2014, to 4 to 6 per week in 2015-2016, to 4 to 6 per day in 2017. HCPOP Operations Unit must also provide instantaneous vacant bed information for HCPOP Classification Services Representative/Correctional Counselor IIIs in order for them to make immediate transfer endorsements to the inpatient programs. The information provided in the reports is fundamental to facilitating timely transfer endorsements, demonstrating compliance with the mandated transfer time frames, and ensuring effective bed management. The three Health Program Specialists requested are needed to ensure information, data and reports are accurate and available to make critical point-in-time decisions regarding bed management in a timely manner.

In addition to staff needed for increased reporting workload, HCPOP has direct transfer endorsement and/or referral bed management responsibilities for 3,755 medical and mental health care beds, including 1,647 PIP beds and 449 MHCBS. In the last several years, the responsibilities of HCPOP expanded dramatically, and the program implemented many significant improvements to data systems to provide timely and proper endorsements, as well as reliable and consistent oversight and reporting to the Courts.

HCPOP has seen the total number of new Acute, new Intermediate, and Mental Health Crisis Bed referrals within the institutions more than triple, from an average of 440 per month in 2012 to 1,423 per month for the first half of calendar year 2017. HCPOP has sole responsibility for reviewing each file and Classification Services Representative/ Correctional Counselor IIIs who perform the referral work are critical to ensuring compliance with the *Coleman* Court mandated timeframes, preventing an endorsement backlog, and avoiding assessment of the \$1,000 per day penalty for patients who exceed mandated transfer timeframes. HCPOP has three days to process each ICF referral and one day to process each Acute referral. Approximately 50 percent of the 4,253 HCPOP endorsements completed between May 2016 and June 2017, were to Acute programs.

Additional Classification Services Representative/Correctional Counselor IIIs and Health Program Specialist staff are critical to ensuring compliance with *Coleman* Court mandated time frames and to prevent an endorsement backlog. By increasing Classification Services Representative/ Correctional Counselor III's for the case reviews and transfer endorsements in HCPOP, as well as bed management, patients requiring

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these higher levels of care will be able to transfer and receive the required mental health treatment in less time. Additionally, the endorsement timeframes will be reduced with these additional staff and allow for patients to move to their LRH more timely. (See Attachment D – Correctional Counselor III Workload Analysis.)

The HCPOP staffing request (8.0 positions) is as follows:

- 1.0 Health Program Specialist II
- 2.0 Health Program Specialist I
- 5.0 Correctional Counselor III's

Mental Health Crisis Bed Adjustments

MHCB referral trends have shown that there is an insufficient number of female MHCBs overall and an insufficient number of male MHCBs in the Southern Region of California. During the spring and summer months, bed availability in Central and Northern California is also limited, resulting in transfer timelines beyond the 24 hour requirement. By flexing 60 existing licensed ICF level beds, transferring 20 MHCB from Northern to Southern California, and adding 15 MHCBs and 5 female flex beds, CDCR will have increased ability to place patients into inpatient facilities within required timelines.

Flex Beds – Male Institutions

CDCR requests to staff 60 existing ICF beds at a level of care that will allow for the beds to transition between different levels of care to accommodate unexpected spikes in the inpatient mental health treatment populations. The Mental Health population projections indicate that the State has enough inpatient capacity overall; however, to meet the needs of each inpatient level of care, beds must be able to transition between the MHCB, Acute, or ICF level based on the demand of the referrals. The ability to flex these inpatient beds will allow CDCR to manage the patient referrals and transfers to meet timelines and help CDCR manage the need for higher levels of care within the Mental Health program as needed.

The flex beds will be located at California Medical Facility and California Health Care Facility to allow increases in the different levels of care. The MHCB need spikes in the spring and summer months, and having the ability to create MHCBs as needed will allow for a more timely response to fluctuations in bed needs throughout the system. These two units will help alleviate the need for alternative housing and help meet the 24 hour time frames for patients in need. The flex beds are an attempt to maximize the bed resources within the system and give CDCR the ability to manage different levels of care in one unit as needs arise in the patient population.

The Flex Bed staffing request (54.8 positions) is as follows:

Mental Health Staffing for 60 Flex Beds (27.8 Positions)

- 0.9 Senior Psychologist Supervisor
- 7.6 Staff Psychiatrist
- 10.1 Clinical Psychologist
- -0.5 Licensed Clinical Social Worker
- 4.4 Office Technician
- 5.3 Recreational Therapist

California Health Care Facility Flex Beds, Custody (5.4 Positions)

- 1.0 Correctional Counselor I
- 1.0 Correctional Counselor III
- 3.4 Correctional Officer

California Medical Facility Flex Beds, Custody (21.6 Positions)

- 1.0 Correctional Counselor I
- 1.0 Correctional Counselor III
- 1.8 Correctional Sergeant
- 17.8 Correctional Officer

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California State Prison, Sacramento/ RJ Donovan Correctional Facility MHCB Relocation

The current shortage of MHCBs in Southern California has resulted in CDCR having to transfer Southern Region patients to the Northern Region for the MHCB level of care. These movements take significant time and coordination and prevent CDCR from moving patients to the appropriate level of care within 24 hours as required by the Mental Health Program guidelines. Therefore, CDCR proposes to relocate an existing 20 MHCB unit from California State Prison, Sacramento to RJ Donovan Correctional Facility. This will increase needed MHCB space in the Southern Region of the State and help mitigate these problems by providing greater access to the appropriate level of care beds in the Southern Region.

Staffing for the MCHBs at RJ Donovan Correctional Facility will be redirected from California State Prison, Sacramento, so no additional authority is required.

Additional Beds – California Institution for Women

Given the census and waitlist figures and the volatility of the female mental health population, there is a need to increase the overall capacity; therefore, CDCR proposes to add 15 MHCBs and 5 flex beds to California Institution for Women. These additional beds will increase CDCR's ability to place female patients into the appropriate levels of care more timely.

The MHCB staffing request (40.2 Positions, all at California Institution for Women) is as follows:

- 0.4 Senior Psychologist Supervisor
- 2.8 Staff Psychiatrist
- 4.0 Clinical Psychologist
- 0.5 Licensed Clinical Social Worker
- 2.8 Office Technician
- 2.4 Recreational Therapist
- 0.4 Senior Psychiatrist Supervisor
- 10.6 Registered Nurse
- 4.4 Psychiatric Technician
- 1.0 Supervising Registered Nurse II
- 2.4 Correctional Officer (1.4 X 1.71 Relief)
- 1.4 Registered Nurse, Correctional Facility
- 1.3 Licensed Vocational Nurse
- 4.0 Psychiatric Technician (Safety)
- 0.8 Senior Psychiatric Technician (Safety)
- 1.0 Correctional Counselor I

Preparing California Institution for Women and RJ Donovan Correctional Facility for the additional crisis beds requires some retrofitting of the facility. The anticipated costs for these retrofits are \$636,000 for California Institution for Women and \$500,000 for RJ Donovan Correctional Facility. Among the items included in retrofitting the facilities are: ligature resistance modifications in the cells, cuff ports on the cell doors, ligature resistance modifications in the showers, and voice/data connectivity.

Mental Health Projections

The CDCR's Office of Research is responsible for producing and publishing timely and accurate population projections for adult institutions, juvenile facilities, and parole using historical population trend data and time series forecasting techniques. These projections are used, among other things, to prepare the Department's annual budget. For the mental health projections, CDCR currently contracts with McManis Consulting to prepare the projections using a methodology approved by the Federal Court. HCPOP currently works with McManis to complete these projections and currently does most of the projection with McManis, being an independent party validating the data. CDCR uses these projections to, among other things, develop the annual mental health population budget. In December 2018, the contract with McManis will expire and, if approved by the court, CDCR will begin producing the mental health projections using the same set of

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methodologies McManis uses to generate the projections in-house. While HCPOP has experience with the court-approved methodology, the Office of Research has more experience with projections for the department overall and may be able to overlay that experience with the mental health population projections. The Office of Research will require additional resources to begin work on adapting the existing McManis mental health population projections model to the Office of Research model.

The Office of Research will begin using the same methodologies, or a similar set acceptable to the Federal Court, to generate the mental health population projections in house. This will allow the Office of Research to assume the responsibility of producing and publishing the mental health population projections and will integrate this effort into its ongoing simulation model development project. It will also allow the Department to pursue the possibility of eventually eliminating the contract. It is expected that three consecutive years (FY 2018-19, FY 2019-20, FY 2020-21) of effort will be necessary to establish a population data baseline for the new mental health projections model. During this three-year period, efforts will also be directed to prepare forecasts using time series methodology with any existing historical data.

This proposal requests additional resources to demonstrate to the court that CDCR has the capability to carry out these responsibilities in-house moving forward.

The Office of Research staffing request (9.0 positions) is as follows:

- 1 Research Manager II
- 1 Research Specialist II
- 2 Research Program Specialist II
- 1 Research Program Specialist I
- 1 Research Analyst I/II
- 1 Office Technician
- 1 Staff Information Systems Analyst
- 1 Senior Programmer Analyst

Descriptions of the duties for these positions may be found in Attachment E - Proposed Office of Research Mental Health Population Projections Staffing. Workload analyses for the positions may be found in Attachments F-1 through F-8 - Proposed Office of Research Workload Analyses.

E. Outcomes and Accountability

These resources will be allocated to improve the compliance rate for timely MHCB and inpatient transfers to address stated deficiencies in the ongoing litigation related to the *Coleman* case. The development of monitoring and oversight processes for the inpatient programs will ensure patients are being moved to their LRH in the inpatient programs which will reduce inpatient waitlists. These processes will also impact the MHCB waitlist issues by reducing the patients' lengths of stay in the MHCBS. These actions will assist the Mental Health Program to come into compliance with the transfer timelines in policy and reduce or avoid the monetary sanctions currently imposed by the Court. Currently, CDCR provides monthly reports to the Court on compliance with the MHCB and inpatient transfer timelines. In addition, the Division of Health Care Services reviews and reports to leadership on a daily basis any inpatient transfer delays. Failure to adequately implement these new and enhanced processes will result in continued and possibly increased monetary sanctions by the Court.

F. Analysis of All Feasible Alternatives

Alternative 1: Approve \$20.1 million General Fund and 115.9 positions in 2018-19 and ongoing to address mental health treatment bed capacity, improve health care data reporting, and manage patient referrals.

Pros:

- Provides the resources to adequately monitor and provide clinical reviews of patients housed out of their LRH in the inpatient programs.
- Provides headquarters oversight of MHCB lengths of stay.
- Increases access to MHCBS, particularly in Southern California.

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- Provides flexibility among the MHCBS, Acute, and ICF beds, which ensures that patients are assigned to their respective LRH.
- Allows CDCR/CCHCS to meet patient transfer timelines, thereby avoiding incurring fines from the Federal Court.
- Addresses the *Coleman* Court's mandate regarding mental health population projections.
- Provides continuity of projections at the expiration of the McManis contract.
- Gives CDCR/CCHCS the ability to produce more timely population reports, and allows for projections to align more with how the rest of the projections for CDCR are done.
- Enhances the Department's reporting ability, especially to the Governor's Office, *Coleman* Court, Office of Legal Affairs, Attorney General, California Department of Finance, and other stakeholders.

Cons:

- Impact to the General Fund.

Alternative 2: Approve \$18.9 million General Fund and 104.9 positions in 2018-19 and ongoing to improve the monitoring and reporting of patient movement; address the expanded need for data analysis and reporting to internal and external stakeholders; and establish additional MHCBS at California Institution for Women and RJ Donovan Correctional Facility, as well as a combined 60 flex beds between California Health Care Facility and California Medical Facility.

Pros:

- Provides the resources to adequately monitor and provide clinical reviews of patients housed out of their LRH in the inpatient programs.
- Provides headquarters oversight of MHCBS lengths of stay.
- Increases access to MHCBS, particularly in Southern California.
- Provides flexibility among the MHCBS, Acute, and ICF beds, which ensures that patients are assigned to their respective LRH.
- Allows CDCR/CCHCS to meet patient transfer timelines, thereby avoiding incurring fines from the Federal Court.
- Enhances the Department's reporting ability, especially to the Governor's Office, *Coleman* Court, Office of Legal Affairs, Attorney General, California Department of Finance, and other stakeholders.

Cons:

- Does not address the *Coleman* Court's mandate regarding mental health population projections.
- Does not provide continuity of projections at the expiration of the McManis contract.
- Limits CDCR/CCHCS' flexibility to produce population projection reports to satisfy the *Coleman* Court and other stakeholders.

Alternative 3: Approve \$16.2 million General Fund and 101.9 positions in 2018-19 and ongoing to transfer the responsibility for mental health projections from an outside vendor; and establish additional MHCBS at California Institution for Women and RJ Donovan Correctional Facility, as well as a combined 60 flex beds between California Health Care Facility and California Medical Facility.

Pros:

- Increases access to MHCBS, particularly in Southern California.
- Provides flexibility among the MHCBS, Acute, and ICF beds.
- Addresses the *Coleman* Court's mandate regarding mental health population projections.
- Provides continuity of projections at the expiration of the McManis contract.
- Gives CDCR/CCHCS the ability to produce more timely population reports, and allows for projections to align more with how the rest of the projections for CDCR are done.
- Enhances the Department's reporting ability, especially to the Governor's Office, *Coleman* Court, Office of Legal Affairs, Attorney General, California Department of Finance, and other stakeholders.

Cons:

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- Does not provide the resources to adequately monitor and provide clinical reviews of patients housed out of their LRH in the inpatient programs.
- Does not address increasing reporting requirements of the *Coleman* Court and other stakeholders.
- Does not provide the resources to adequately monitor and provide clinical reviews of patients housed out of their LRH in the inpatient programs.
- Compromises CDCR/CCHCS' ability to meet patient transfer timelines, thereby exposing the Department to incurring fines from the Federal Court.
- Does not provide headquarter oversight of MHCB lengths of stay.
- Does not ensure that patients are assigned to their respective LRH.

Alternative 4: Approve \$10.5 million General Fund and 61.1 positions in 2018-19 and ongoing to improve the monitoring and reporting of patient movement; address the expanded need for data analysis and reporting to internal and external stakeholders; transfer the responsibility for mental health projections from an outside vendor; and establish additional MHCBs at California Institution for Women and RJ Donovan Correctional Facility.

Pros:

- Provides the resources to adequately monitor and provide clinical reviews of patients housed out of their LRH in the inpatient programs.
- Provides headquarters oversight of MHCB lengths of stay.
- Provides limited increase to MHCBs, particularly in Southern California.
- Addresses the *Coleman* Court's mandate regarding mental health population projections.
- Provides continuity of projections at the expiration of the McManis contract.
- Gives CDCR/CCHCS the ability to produce more timely population reports, and reports that are more in line with how current population projections are completed for CDCR.
- Enhances the Department's reporting ability, especially to the Governor's Office, *Coleman* Court, Office of Legal Affairs, Attorney General, California Department of Finance, and other stakeholders.

Cons:

- Limits flexibility among the MHCBs, Acute, and ICF beds.
- Fails to ensure that patients are assigned to their respective LRH.
- Compromises CDCR/CCHCS' ability to meet patient transfer timelines, thereby exposing the Department to incurring fines from the Federal Court.

G. Implementation Plan

Implementation of this plan effective July 1, 2018.

H. Supplemental Information

Attachment A – *Coleman* Court Order, April 19, 2017

Attachment B – MHCB Average Length of Stay, May 13, 2017 – July 12, 2017

Attachment C – HCPOP Description of Distributed Reports

Attachment D - Correctional Counselor III Workload Analysis

Attachment E – Office of Research Mental Health Population Projections Staffing

Attachments F-1 through F-8 – Proposed Office of Research Workload Analyses

I. Recommendation

Alternative 1: Approve \$20.1 million General Fund and 115.9 positions in 2018-19 and ongoing to address mental health treatment bed capacity, improve health care data reporting, and manage patient referrals.

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8 UNITED STATES DISTRICT COURT
9 FOR THE EASTERN DISTRICT OF CALIFORNIA
10

11 RALPH COLEMAN, et al.,

12 Plaintiffs,

13 v.

14 EDMUND G. BROWN, JR., et al.,

15 Defendants.
16

No. 2:90-cv-0520 KJM DB P

ORDER

17
18 In an order filed March 24, 2017, this court directed defendants to show cause in
19 writing why they should not be required to come into full and permanent compliance with
20 Program Guide¹ timelines for transfer to acute and intermediate care facility (ICF) mental health
21 care by May 15, 2017. ECF No. 5583 at 2, 25. The court also directed the parties to brief why
22 defendants should not be required to comply with the Program Guide twenty-four hour timeline
23 for transfer to mental health crisis beds (MHCBs) by the same date and, if so, whether full or 90
24 percent compliance across all California Department of Corrections and Rehabilitation (CDCR)
25

26 ¹ The Mental Health Services Delivery System Program Guide, 2009 Revision, is the
27 operative remedial plan in this action. *See Coleman v. Brown*, 938 F. Supp. 2d 955, 961 (E.D.
28 Cal. 2013). It is called, variously, the Program Guide or the Revised Program Guide. References
in this order to the “Program Guide” or the “Revised Program Guide” are to this document.

institutions should be required. *Id.* at 2. Finally, the court directed the parties to brief how such orders, if made, should be enforced as well as whether monetary sanctions are an appropriate remedy for non-compliance with such orders. *Id.* The parties have timely filed the briefs required by the March 24, 2017 order. *See* ECF Nos. 5593, 5595.

I. BACKGROUND

The background and history contained in the March 24, 2017 order is incorporated by reference in this order. *See* ECF No. 5583 at 2-8. The issue currently before the court is enforcement of provisions of defendants' plan to remedy Eighth Amendment violations in the delivery of mental health care to class members. In relevant part, the Program Guide requires:

1. Any inmate referred to an MHCB be transferred within 24 hours of referral;
2. Any inmate referred to any acute inpatient mental health placement be transferred within ten days of referral, if accepted by Department of State Hospitals (DSH)²; and
3. Any inmate referred to any intermediate care mental health placement be transferred within 30 days of referral, if accepted by DSH.

Program Guide at 12-1-16. It is well-established that defendants have a constitutional obligation to provide class members with "access to adequate mental health care." *Coleman v. Wilson*, 912 F.Supp. 1282, 1301 (E.D. Cal. 1995); *see also Coleman v. Brown*, 938 F.Supp.2d at 981. The time frames for transfer to inpatient care contained in the Program Guide "represent defendants' considered assessment of what is sufficiently 'ready access' to each level of care." *Coleman v. Brown*, 938 F.Supp.2d at 981. The court turns first to compliance with the timelines for transfer to acute and ICF inpatient care.

II. ARGUMENTS OF THE PARTIES

A. Plaintiffs' Response

In their brief, ECF No. 5593, plaintiffs contend (1) the court should order defendants to come into full and permanent compliance with Program Guide timelines for transfer

² Acceptance of referrals by DSH is governed by standards set out in an Administrative Letter dated November 2015 and offered into evidence at the January 23, 2017 hearing as Plaintiffs' Exhibit A.

1 to inpatient care by May 15, 2017; (2) the court's order can and should be enforced through civil
2 contempt proceedings; (3) the court has authority to impose monetary sanctions if necessary to
3 coerce compliance but that defendants must be given an opportunity to reduce or avoid such
4 sanctions through compliance; (4) there is a risk imposition of fines would discourage defendants
5 from referring inmate-patients, or encourage rescission of necessary referrals and therefore
6 "careful reporting and monitoring will be required" if this remedy is chosen; (5) the existing data
7 templates are insufficient to allow enforcement of the court's order; (6) the court should order
8 defendants to come into compliance with Program Guide timelines for MHCBS by May 15, 2017
9 and should require 100 percent compliance; and (7) before enforcing an order requiring
10 compliance with MHCBS Program Guide timelines, the court should take additional evidence to
11 determine the obstacles to full compliance and ascertain whether targeted remedial orders are
12 required prior to imposition of monetary sanctions.

13 B. Defendants' Response

14 1. Summary

15 Defendants oppose issuance of an enforcement order and consideration of
16 monetary sanctions for non-compliance. Defendants contend requiring full compliance with
17 Program Guide timelines "is not consistent with the constitutional standard or the Prison
18 Litigation Reform Act." ECF No. 5595 at 3. Defendants argue that "whether system-wide
19 constitutional deficiencies exist, does not depend on whether the Court's remedial plan has been
20 fully accomplished. Rather, the question is whether State officials are deliberately indifferent to
21 serious mental-health needs." *Id.* at 12. In a similar vein, they contend requiring full compliance
22 with the Program Guide timelines "is at odds with the constitutional deliberate indifference
23 standard" and therefore should not be the benchmark for imposition of monetary sanctions. *Id.* at
24 15.

25 Defendants further contend imposition of monetary sanctions would violate the
26 Prison Litigation Reform Act "because such relief extends further than necessary to remedy
27 constitutional violations." *Id.* at 13. For the reasons set forth in this order, the court finds that full
28 and permanent compliance with Program Guide timelines for transfer to inpatient care is

1 necessary to remedy constitutional violations identified in this action. The court has found, and
2 defendants have acknowledged, that full and permanent compliance with these timelines is
3 feasible. For that reason, the court finds that continued non-compliance would only be
4 remediable through an order of contempt and imposition of coercive monetary sanctions and,
5 therefore, that such relief, if required, would be necessary to remedy the constitutional violation.

6 2. Analysis

7 Defendants' contentions call for a review of two issues: (1) the role of the
8 deliberate indifference standard at this stage of these proceedings; and (2) the role of the Program
9 Guide in assessing constitutional compliance.

10 Defendants' argument concerning the role of the deliberate indifference standard
11 misses the mark and fails to recognize that the court already has repeatedly addressed and rejected
12 this argument, albeit in different contexts. In denying defendants' 2013 motion to terminate these
13 proceedings, the court considered and rejected an argument made by defendants that they are no
14 longer "deliberately indifferent" to the need to provide constitutionally adequate mental health
15 care and therefore should no longer be subject to court supervision. *See Coleman v. Brown*, 938
16 F.Supp.2d at 988-89. Subsequently, in a 2014 order on plaintiffs' motion for enforcement of
17 court orders and additional relief related to use of excessive force, disciplinary measures, and
18 housing and treatment of class members in administrative segregation units (ASUs) and
19 segregated housing units (SHUs), the court again rejected this argument, holding that

20 once an Eighth Amendment violation is found and injunctive relief
21 ordered, the focus shifts to remediation of the serious deprivations
22 that formed the objective component of the identified Eighth
23 Amendment violation. *See Coleman v. Brown*, 938 F.Supp.2d at
24 988. Remediation can be accomplished by compliance with
25 targeted orders for relief or by establishing that the "violation has
26 been remedied in another way." *Id.* To the extent the subjective
27 component of an Eighth Amendment violation remains a relevant
28 inquiry, it is coextensive with proof of ongoing objectively
29 unconstitutional conditions. *Id.* at 989.

30 *Coleman v. Brown*, 28 F.Supp.3d 1068, 1077 (E.D. Cal. 2014).

31 The relevant inquiry at this juncture is what, objectively, is required to achieve
32 complete remediation of the constitutional violation with respect to access to inpatient care.

1 Defendants contend compliance with the Program Guide “should not measure whether defendants
2 have discharged their constitutional obligations to provide adequate mental health treatment to
3 inmate-patients” and that “[i]nstead, the Court should assist the Defendants by declaring
4 standards for system-wide performance that must be met to satisfy the Eighth Amendment.
5 Substantial compliance with the Program Guide, based on system-wide performance, should be
6 the standard.” ECF No. 5595 at 12-13.

7 In the 2013 order cited by defendants in their brief, the court discussed the role of
8 the Program Guide in assessing defendants’ compliance with the Eighth Amendment. The court
9 did so in the context of “defendants’ pervasive objection that the Special Master is not
10 monitoring with reference to a constitutional standard,” addressing what it described as “the
11 fallacy” in that objection. ECF No. 4361 at 6. In particular, the court described at length the
12 development of the Program Guide and its relationship to the requirements of the Eighth
13 Amendment. *Id.* at 4-6. As the court wrote, the Program Guide “represents *defendants’*
14 considered assessment, made in consultation with the Special Master and his experts, and
15 approved by this court, of what is required to remedy the Eighth Amendment violations identified
16 in this action and meet their constitutional obligation to deliver adequate mental health care to
17 seriously mentally ill inmates.” *Id.* at 3 (emphasis in original). In that context, the court found
18 that because the Program Guide “is grounded in the requirements of the Eighth Amendment as
19 they have been developed in the context of this action, *see Coleman v. Wilson*, 912 F.Supp. 1282,
20 1301 (E.D. Cal. 1995), the Special Master’s Report to the court on defendants’ compliance with
21 the provisions of the . . . Program Guide is also grounded in the requirements of the Eighth
22 Amendment. . .” *Id.*

23 In the present context, the transfer timelines in the Program Guide reflect
24 defendants’ considered assessment of how to fulfill their constitutional obligation to provide class
25 members with “ready access” to inpatient mental health care – an assessment accepted and
26 blessed by the court. *See* ECF No. 5583 at 14 (quoting *Coleman v. Brown*, 938 F.Supp.2d at 981,
27 in turn quoting *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982)). Compliance with those
28 timelines is a necessary part of a complete remedy in this action.

III. COMPLIANCE WITH ACUTE AND ICF TIMELINES

The history of problems with access to inpatient care and their sequelae, laid out several times and most recently in the court's March 24, 2017 order, *see* ECF No. 5583 at 4-6, shows clearly that full and permanent elimination of waitlists for inpatient care that exceed Program Guide timelines is necessary to provide constitutionally adequate access to inpatient mental health care for class members. That history, and the record before the court, also demonstrate that issuance of a specific order requiring full and permanent compliance with Program Guide timelines, subject to clearly defined exceptions to be developed through a meet and confer process and incorporated as an addendum in the Program Guide,³ is necessary to achieve remediation of this aspect of the Eighth Amendment violation in this case. The options available to defendants for achieving this compliance are described in the March 24, 2017 order and incorporated by reference in this order. *See* ECF No. 5583 at 8-21.

A. Full Compliance by May 15, 2017 Deadline

In their response to the March 24, 2017 order, defendants represent that by May 15, 2017, there will be no inmate-patients waiting beyond Program Guide timelines for transfer to inpatient care, *see* ECF No. 5595 at 1, and defendants describe specific steps they will take to achieve this. *Id.* at 1-2. Defendants contend these circumstances, together with additional steps they are taking to achieve permanent elimination of waitlists for inpatient care that exceed Program Guide timelines, obviates the need for court intervention. *Id.* at 3. Defendants ignore the lengthy history, laid out in the March 24, 2017 order, of repeated re-emergence of large numbers of inmate-patients waiting well past Program Guide timelines for transfer to inpatient care and, as recently as six years ago, for identification and referral for such essential mental

³ The Special Master has informed the court that the parties are in the preliminary stages of updating the Program Guide to incorporate modifications required by court orders issued since March 2006, when the court gave final approval to most of the Program Guide. The court encourages development and implementation of a process for the addition of such addenda to the Program Guide, for example through use of so-called “pocket parts.” This process, of course, is not an opportunity to renegotiate matters that have been settled by court order. Instead, it is a necessary step toward completion of a full and final remedy, with a user-friendly comprehensive Program Guide.

1 health care. ECF No. 5583 at 4-7. Each time, the court has intervened and the Special Master
2 and the parties have expended considerable time and effort assessing the unmet need for care,
3 identifying additional bed capacity, and/or developing new plans to address the continuing
4 constitutional violation evidenced by the waitlists. As the court made clear in the March 24, 2017
5 order, this cycle must be broken. *Id.* at 8. To that end, the court will enter a specific order
6 requiring defendants, by May 15, 2017, to come into full compliance with Program Guide
7 timelines for transfer of inmate-patients to acute and intermediate care facility programs.

8 B. Permanent Compliance

9 Defendants outline a number of steps they are taking, both in the short term and in
10 the long term, to permanently eliminate waitlists that exceed Program Guide timelines. *See* ECF
11 No. 5595 at 3-8. For the reasons set forth in section III(A), the court will also enter a specific
12 order requiring, effective May 15, 2017, permanent compliance with Program Guide timelines for
13 transfer of inmate-patients to acute and intermediate care facility programs.

14 C. Clarification Regarding Possible Exclusions

15 In the March 24, 2017 order, the court signaled its intention, for purposes of
16 enforcement by this court, to exclude from the ten and thirty-day periods in which transfer to
17 inpatient care must occur “any time a class member referred to inpatient mental health care
18 spends in treatment for medical needs deemed more urgent than the mental health need that led to
19 the inpatient referral, or any time a class member spends on out-to-court status pursuant to a court
20 order or subpoena.” *Id.* at 25. Plaintiffs contend such a blanket exclusion is too broad and based
21 only on a “cursory assertion” by Pamela Ahlin, Director of the Department of State Hospitals.
22 ECF No. 5593 at 9. Plaintiffs contend (1) defendants should be permitted to make an
23 individualized showing for any inmate-patient held beyond Program Guide timelines; and
24 (2) defendants should continue and complete the referral process for any inmate-patient referred
25 to inpatient mental health care who is also subject to a medical hold or legal proceedings at any
26 step in the process. *Id.* at 9-10. Plaintiffs also observe that the monthly bed utilization reports
27 currently filed with the court do not identify medical holds or out-to-court status. *Id.* at 10.

1 As the court made clear in the March 24, 2017 order, it has no intention of
2 micromanaging defendants in this process. That said, the record suggests there are circumstances
3 under which time after an inmate-patient has been referred to inpatient mental health care should
4 not be included in the required timelines for transfer to such care. This in turn, as plaintiffs
5 observe, raises questions about how the referral process should proceed when such circumstances
6 are present. An addendum to the Program Guide that identifies circumstances under which time
7 after an inmate-patient is referred to inpatient mental health care should be excluded from
8 Program Guide timelines for transfer to such care, and also identifies timelines for completion of
9 the referral process when such circumstances are present, will be necessary going forward. The
10 parties will be directed to meet and confer under the supervision of the Special Master to develop
11 an addendum to the Program Guide that addresses these matters. Said addendum shall be
12 completed and submitted to the court for review and final approval within forty-five days.

13 D. Enforcement

14 Plaintiffs propose “that the Court issue an order setting forth a framework
15 involving monthly reporting and prospective, presumptive fines that may ultimately be avoided
16 through compliance.” ECF No. 5593 at 13. Under the proposed framework, defendants would be
17 required to track on a daily basis any inmate-patient waiting past Program Guide timelines for
18 transfer to inpatient care and to include this information in their monthly reports to the court. *Id.*
19 Defendants would be permitted to file sworn declarations attesting to all steps taken to comply
20 with the court’s order. *Id.* The order would also provide for a fine of up to \$1000 per day, per
21 inmate-patient, for each violation, and the fines would be held in abeyance for a period of six
22 months to give defendants the opportunity to “cure, or purge, their non-compliance before the
23 issuance of monetary sanctions.” *Id.* at 14. Plaintiffs propose that if defendants are not fully
24 compliant with Program Guide timelines starting in May 2017 and continuing for six months, the
25 court hold a contempt hearing consistent with due process requirements. *Id.* As discussed above,
26 defendants oppose issuance of an enforcement order as well as enforcement of any such order
27 through contempt proceedings or otherwise.

1 As the court noted in the March 24, 2017 order, it is well-established that the court
2 has authority to impose monetary sanctions to compel compliance with its orders. *See* ECF No.
3 5583 at 26 (citing *U.S. v. United Mine Workers of America*, 330 U.S. 258, 303-04 (1947)).

4 Where the purpose of a fine is to make defendants comply with a
5 court order, the court is required to “consider the character and
6 magnitude of the harm threatened by continued contumacy, and the
7 probabl[e] effectiveness of any suggested sanction in bringing
8 about the result desired.” *Id.* at 304. Civil fines “designed to
9 compel future compliance with a court order, are considered to be
coercive and avoidable through obedience, and thus may be
imposed in an ordinary civil proceeding upon notice and an
opportunity to be heard.” *International Union, United Mine
Workers of America v. Bagwell*, 512 U.S. 821, 827 (1994).

10 ECF No. 5583 at 26.

11 “A court’s contempt powers are broadly divided into two categories: civil
12 contempt and criminal contempt. . . . ‘The purpose of civil contempt is coercive or
13 compensatory, whereas the purpose of criminal contempt is punitive.’” *Shell Offshore Inc. v.*
14 *Greenpeace, Inc.*, 815 F.3d 623, 628 (9th Cir. 2016) (quoting *Koninklijke Philips Elecs. N.V. v.*
15 *KXD Tech., Inc.*, 539 F.3d 1039, 1042 (9th Cir. 2008) (internal citation omitted)). “A court may
16 wield its civil contempt powers for two separate and independent purposes: (1) ‘to coerce the
17 defendant into compliance with the court’s order’; and (2) ‘to compensate the complainant for
18 losses sustained.’” *Shell Offshore Inc.*, 815 F.3d at 628 (quoting *United Mine Workers of*
19 *America*, 330 U.S. at 303-04). Due process requires notice and an opportunity to be heard prior
20 to imposition of sanctions for contempt of a court order. *Lasar v. Ford Motor Co.*, 399 F.3d
21 1101, 1109-10 (9th Cir. 2005). In addition, “[w]here a fine is not compensatory, it is civil only if
22 the contemnor is afforded the opportunity to purge.” *International Union, United Mine Workers*
23 *of America*, 512 U.S. at 829. Thus, a civil contemnor must be given an “opportunity to reduce or
24 avoid [a] fine through compliance.” *Id.* (citing *Penfield Co. of Cal. v. SEC*, 330 U.S. 585, 588
25 (1947)).

26 In light of the foregoing principles, the court now notifies defendants that the
27 provisions of this order requiring them to come into full and permanent compliance with Program
28

1 Guide timelines for transfer to inpatient care by May 15, 2017 will be enforceable by civil
2 contempt proceedings and, if necessary, imposition of monetary sanctions to coerce compliance.

3 Beginning with their May 15, 2017 Census and Waitlists Report for Inpatient
4 Mental Health Care (monthly report),⁴ defendants shall include in the monthly report (1) the total
5 number of inmate-patients, if any, who waited beyond Program Guide timelines for transfer to an
6 acute inpatient mental health care program; (2) the total number of inmate-inpatients, if any, who
7 waited beyond Program Guide timelines for transfer to an ICF mental health care program; (3) the
8 number of days each inmate-patient waited beyond Program Guide timelines; and (4) the total
9 number of inmate-patient wait days for the month (category (1) plus category (2) plus category
10 (3)). Fines in the amount of \$1,000 per inmate-patient per day will begin accumulating on May
11 16, 2017.

12 Pending development of the Program Guide addendum required by this order, *see*
13 Section III(C), *supra*, defendants shall include with their monthly report the total number of
14 inmate-patient days they believe should be excluded from the total reported and an explanation
15 why those days should be excluded. In addition, defendants shall report to the Special Master on
16 a monthly basis concerning all inmate-patients referred for inpatient care whose referrals are
17 rejected or rescinded and, to the extent defendants do not already provide this information, the
18 reason(s) for the rejections or rescissions. The Special Master will be directed to report to the
19 court forthwith should there be an appreciable increase in the number of such rejections and/or
20 rescissions.

21
22 _____
23 ⁴ The templates submitted by defendants on March 15, 2017, ECF No. 5577, are
24 approved, with the additions required by this order. Plaintiffs' objections to the omission of
25 certain templates and data, *see* ECF No. 5582, remain pending before the court and will be
26 resolved by subsequent order. It is the court's view that, as a general matter, point-in-time data
27 represents at best a partial snapshot of information relevant to remediation of these matters and
28 the additional templates plaintiffs seek would appear to be most useful to defendants as an aid in
identification and targeted remediation of any ongoing non-compliance with Program Guide
timelines. In view of the court's decision to proceed with enforcement of the Program Guide
timelines, the issue now is whether such trend data needs to be filed with the court. Again, that
will be resolved by subsequent order.

1 This matter will be set for hearing on November 3, 2017 at 10:00 a.m. in
2 Courtroom # 3 for consideration of findings of contempt and requirement of payment of fines that
3 may have accumulated on or after May 16, 2017. If no fines have accumulated, the hearing will
4 be vacated. Given the representations by defendants in their brief concerning the steps they are
5 taking, *inter alia*, to add capacity as well as to ensure appropriate inpatient bed utilization and
6 timely movement of inmate-patients to inpatient programs consistent with the inmates' least
7 restrictive housing (LRH) designations, the court is hopeful that contempt proceedings will not be
8 required and, instead, that defendants will finally achieve full, ongoing, and permanent
9 compliance with this aspect of their remedial plan.

10 IV. COMPLIANCE WITH MHCB TRANSFER TIMELINES

11 The court has also directed the parties to brief whether a court order requiring
12 compliance with Program Guidelines for transfer to MHCBs should require 90 percent
13 compliance across CDCR institutions or 100 percent compliance with defined exceptions as
14 appropriate, and whether a similar order imposing monetary sanctions for violations is an
15 appropriate remedy. *See* ECF No. 5583 at 21-23, 25-26.

16 After review of the record and the focused briefing by the parties, the court is
17 persuaded that full compliance with the twenty-four hour timeline for transfer to MHCBs is
18 required to satisfy the Eighth Amendment. An inmate in need of an MHCB level of care is, by
19 definition, in a mental health crisis. *See* Program Guide, 2009 Revision, at 12-5-1. As noted
20 above, the twenty-four hour timeline for transfer to an MHCB represents defendants' assessment
21 of what is necessary to meet their Eighth Amendment obligations to inmates in mental health
22 crises. *See* Section II(B)(2), *supra*. As plaintiffs cogently argue, "[t]he Court would not
23 countenance Defendants' failure to timely transfer one out of every ten prisoners suffering a
24 medical crisis to an emergency room; neither should it permit Defendants to fail to timely transfer
25 one out of every ten prisoners undergoing life-threatening mental health crises" to an MHCB.
26 ECF No. 5593 at 19.

27 While the court intends to issue an enforcement order requiring 100 percent
28 compliance with the twenty-four hour timelines for transfers to MHCBs, subject to exceptions set

1 forth in an addendum to be developed as required by this order, the parties both suggest that
2 defendants could not, at present, comply with such an order. Plaintiffs contend additional
3 evidence is required to understand the “extent and root causes of delayed transfers to MHCBS, to
4 ensure that Defendants’ system is currently capable of full compliance with the Program Guide’s
5 literal transfer timelines requirements, and, if appropriate, to issue further targeted remedial
6 orders subsequent to that hearing and prior to considering monetary sanctions.” ECF No. 5593 at
7 21. Plaintiffs present evidence and a number of focused arguments targeting possible
8 explanations for defendants’ failure to meet the twenty-four hour transfer timeline for MCHBs, as
9 well as asserted omissions in reporting that would assist in understanding and remedying the
10 delays. *See id.* at 22-25. Defendants state “they need additional capacity to completely address
11 the needs of the class” for MHCB care, and they point to a number of “initiatives” they “have
12 undertaken” as part of a continuing effort to meet the needs of class members who require MHCB
13 care. ECF No. 5595 at 8-10.

14 The data available to the court shows the following. The Fall 2016 population
15 projections forecast a need for this year of 495 male MHCBS and 30 female MHCBS. ECF No.
16 5542-1 at 116, 122. Defendants currently have only 427 male MHCBS and 22 female MHCBS.
17 ECF No. 5577 at 11. These data alone suggest defendants do not presently have sufficient
18 capacity to meet the need for MHCB level of care. Moreover, defendants’ reporting to the court
19 does not capture completely the scope of delays. According to defendants’ March 15, 2017
20 monthly report, as of February 27, 2017, six male inmates and six female inmates had been
21 waiting more than twenty-four hours for MHCB placement. *Id.* However, the HCPOP report for
22 February 2017 shows that of 671 inmates placed in MHCBS in February 2017, 507 were placed
23 within the twenty-four hour time frame while 164 waited longer than twenty-four hours for
24 placement. A copy of the last page of that report is attached as Exhibit A to this order. The briefs
25 of both parties suggest myriad possible reasons for the ongoing large number of inmates waiting
26 longer than twenty-four hours to be transferred to an MHCB.

27 Good cause appearing, this matter will be set for status conference and, as
28 necessary, evidentiary hearing on August 29, 2017 at 10:00 a.m. The purpose of the status, which

1 will not exceed one day, will be for the court to take evidence on obstacles to full compliance
2 with the Program Guide timeline for transfer to MHCBS and targeted remedies for achieving such
3 compliance. To facilitate preparation for that hearing, the Special Master shall forthwith convene
4 a workgroup to focus on outstanding issues related to compliance with the Program Guide
5 timeline for transfer to MHCBS, including but not limited to (1) use of alternative housing when
6 an inmate-patient is referred to an MHCBS; and (2) any and all obstacles to full compliance with
7 the twenty-four timeline for transfer to MHCBS. The purpose of the workgroup meetings are to
8 identify those issues that must be addressed, to resolve any and all issues the parties can resolve
9 without court intervention, and to identify any issues that remain for consideration and resolution
10 by the court. The workgroup shall also develop an addendum to the Program Guide delineating
11 exceptions, if any, to the twenty-four hour timelines requirement.

12 Not later than July 28, 2017, the parties shall file a joint report, approved by the
13 Special Master, which shall contain (1) a description of issues, if any, resolved by the workgroup
14 and the substance of agreements reached; (2) a focused and comprehensive list of issues that
15 remain for resolution by the court; and (3) a list of witnesses and other evidence the parties
16 propose to offer at the evidentiary hearing. The court encourages the presentation of declarations
17 in lieu of direct testimony, as appropriate. The court will review the submission of the parties and
18 may modify the scope of the evidentiary hearing.

19 In accordance with the above, IT IS HEREBY ORDERED that:

20 1. On or before May 15, 2017, defendants shall come into full and permanent
21 compliance with Program Guide timelines for transfer of inmate-patients to acute and
22 intermediate care facility programs. This order applies to both male and female inmate-patients.
23 This order will be enforceable by civil contempt proceedings and, if necessary, imposition of
24 monetary sanctions to coerce compliance.

25 2. The parties shall meet and confer under the supervision of the Special Master
26 to develop an addendum to the Program Guide that identifies circumstances under which time
27 after an inmate-patient is referred to inpatient mental health care should be excluded from
28 Program Guide timelines for transfer to such care and timelines for completion of the referral

1 process when such circumstances are present. Said addendum shall be completed and submitted
2 to the court for review and final approval within forty-five days.

3 3. Beginning with the May 15, 2017 Census and Waitlists Report for Inpatient
4 Mental Health Care (monthly report), defendants shall include in the monthly report (1) the total
5 number of inmate-patients, if any, who waited beyond Program Guide timelines for transfer to an
6 acute inpatient mental health care program; (2) the total number of inmate-patients, if any, who
7 waited beyond Program Guide timelines for transfer to an ICF mental health care program; (3) the
8 number of days each inmate-patient waited beyond Program Guide timelines; and (4) the total
9 number of inmate-patient wait days for the month (category (1) plus category (2) plus category
10 (3)). Pending development of the addendum required by paragraph 2 of this order, defendants
11 shall include with their monthly report the total number of inmate-patient days they believe
12 should be excluded from the total reported and an explanation why those days should be
13 excluded.

14 4. Beginning on or before May 15, 2017, defendants shall report to the Special
15 Master monthly concerning all inmate-patients referred for inpatient care whose referrals are
16 rejected or rescinded and, to the extent defendants do not already provide this information, the
17 reason(s) for the rejections or rescissions. The Special Master shall report to the court forthwith
18 should there be an appreciable increase in the number of such rejections and/or rescissions.

19 5. This matter is set for hearing on November 3, 2017 at 10:00 a.m. in Courtroom
20 # 3 for consideration of findings of contempt and requirement of payment of fines that may have
21 accumulated on or after May 16, 2017. If no fines have accumulated, the hearing will be vacated.

22 6. This matter is set for status conference and, as necessary, a one day evidentiary
23 hearing on August 29, 2017 at 10:00 a.m. to address achievement of full compliance with the
24 twenty-four hour Program Guide transfer timeline to mental health crisis beds.

25 7. The Special Master shall forthwith convene a workgroup to focus on
26 outstanding issues related to compliance with the Program Guide timeline for transfer to mental
27 health crisis beds as described in this order.

1 8. Not later than July 28, 2017, the parties shall file a joint report, which shall
2 contain (1) a description of issues, if any, resolved by the workgroup and the substance of
3 agreements reached; (2) a focused and comprehensive list of issues that remain for resolution by
4 the court; and (3) a list of witnesses and other evidence the parties propose to offer at the
5 evidentiary hearing. The court will accept declarations in lieu of direct testimony, as appropriate.
6 The court will review the submission of the parties and will advise the parties if it is modifying
7 the scope of any evidentiary hearing.

8 9. The workgroup convened in accordance with paragraph 7 of this order shall
9 also develop an addendum to the Program Guide that identifies exclusions, if any, to the Program
10 Guide timeline for transfer to mental health crisis bed care. Said addendum shall be completed
11 and submitted to the court for review and final approval within forty-five days.

12 DATED: April 19, 2017.

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14 
15 UNITED STATES DISTRICT JUDGE
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**MHCB Average Length of Stay
May 13, 2017 - July 12, 2017**

ATTACHMENT B

Institution	Bed Capacity	Admissions	No. of Discharges	Avg. Clinical LOS
CCWF	12	2	32	9.6
CHCF	98	29	371	12.5
CIM	34	20	100	21.3
CIW	10	2	64	8.4
CMC	50	17	200	10.9
CMF	50	23	138	15.6
COR	24	9	110	11.4
HDSP	10	1	43	7.3
KVSP	12	1	76	7.3
LAC	12	5	78	7.9
MCSP	8	2	46	8.9
NKSP	10	3	38	13.4
PBSP	10	1	32	8.3
PVSP	6	3	26	7.9
RJD	14	7	53	17.5
SAC	24 (+20 unlicensed)	16	98	17.8
SATF	20	8	75	15.3
SOL	9	0	27	8.3
SVSP	10	4	43	11.5
WSP	6	2	26	11.7

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPop)
Description of Distributed Reports (July 2017)

ATTACHMENT C

MANAGEMENT INFORMATION SUMMARY (MIS) REPORTS

Report Name	Description	Data Source	Distribution Frequency
Mental Health Services Delivery System (MHSDS) MIS Report	Weekly snapshot of all Mental Health capacities, census, and wait list information by level of care and gender. Data as of every Monday. Used to monitor programs and facilitate projections, bed planning, and population trending. <i>Sent to upper management/executives. Included in monthly Coleman Court package.</i>	Datamart CDCBeds RIPA Offender Information Services Branch (OISB)	Weekly
Medical MIS Report	Weekly snapshot of all Specialized Medical Bed program capacities, census, and wait list information by treatment setting. Data as of every Monday. Used to monitor programs, and facilitate bed planning and population trending. <i>Sent to upper management/executives.</i>	Datamart CDCBeds	Weekly
Mental Health Population and Percentages	Weekly snapshot of the Mental Health population by gender and level of care, with corresponding percentages of the population.	Datamart CDCBeds RIPA OISB	Weekly

MANAGEMENT INFORMATION REPORTS (DETAIL)

Report Name	Description	Data Source	Distribution Frequency
R1: Mental Health Population By Institution	Capacity and census data for Mental Health <u>outpatient</u> population by institution. Includes Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient (EOP), and Psychiatric Services Unit (PSU). CCCMS and EOP broken down by Administrative Segregation Unit (ASU), General Population, Reception Center (RC), and Secure Housing Unit (SHU). Used to facilitate placements, projections, bed planning, and population trending. <i>Included in monthly Coleman Court package.</i>	Datamart CDCBeds	Daily
R4: EOP by Classification Score	Breakdown of Mental Health EOP population by classification score/level and institution. Used to facilitate projections and bed planning.	Datamart CDCBeds	Daily
R5: Health Care Census by Housing and Treatment Setting	Capacity and census detail for all health care settings by institution. Includes licensed, staffed, and operational capacities. Identifies medical only beds, mental health only beds, and swing beds in Correctional Treatment Center CTC, Outpatient Housing Unit (OHU), and Skilled Nursing Facility settings. Used to facilitate placements, projections, bed planning, and population trending.	Datamart CDCBeds	Daily
Health Care Beds (HCB): Health Care Inpatient and OHU Beds Statewide	List of inpatient and OHU health care beds by institution and Strategic Offender Management System (SOMS) bed number. Identifies whether bed is vacant or filled. If filled, identifies inmate name, number, mental health code, score, and custody level. Also identifies bed status (active/inactive), cell type (safety, observation, fixed restraint), and whether cell is respiratory isolation. Used to facilitate placements.	Datamart CDCBeds	Daily

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPOP)
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ATTACHMENT C

Summary of Vacant OHU Beds Statewide	Filters out all the <u>vacant</u> OHU beds from the HCB report. Used to facilitate placements.	Datamart CDCBeds	Daily
Summary of Vacant Health Care Inpatient Beds Statewide	Filters out all the <u>vacant</u> inpatient beds from the HCB report. Used to facilitate placements.	Datamart CDCBeds	Daily

MENTAL HEALTH CRISIS BED REPORTS

Report Name	Description	Data Source	Distribution Frequency
Mental Health Crisis Bed (MHCB) Pending List – HQ Report	List produced at the end of each day by the HCPop Classification Staff Representatives (CSRs) that track the status of daily MHCB placement referrals and whether the referral is within the <i>Coleman</i> 24-hour transfer timeframe. Used to facilitate placements, projections, bed planning, and population trending.	HEART	Daily and On Demand via HEART
MHCB Coleman Wait List	Report of MHCB referrals without a Bed Assignment and over the Coleman 24-hour transfer timeframe. <i>Included in monthly Coleman Court package.</i>	HEART	On Demand via HEART
MHCB Redline Report	A report from HCPop Endorsements and Referrals Tracking Application (HEART) that shows a Bed Status of “Not in Service” per SOMS. This report is distributed with the MHSMS MIS Report.	HEART	Weekly and On Demand via HEART
MHCB Census	MHCB population by institution from Mental Health Tracking System, as of every Tuesday. Used to facilitate projections, bed planning, and population trending.	HEART	Weekly
Summary of MHCB Referrals and Transfers	Detailed reports regarding the number of MHCB referrals and placements coordinated by HCPop. Includes number transferred vs. rescinded and transfer timeframes. <i>Included in monthly Coleman Court package.</i>	HEART	Monthly
MHCB Timeframes	Detailed report regarding the number of MHCB referrals and placements coordinated by HCPop. Includes all dispositions and disposition timeframes. <i>Included in monthly Coleman Court package.</i>	HEART	Monthly and On Demand via HEART
MHCB Rescind Reasons	Detailed report regarding the number of rescinded MHCB referrals by institution and rescind reason. User enters desired parameters for month and year. User can click on a number (e.g., number of rescissions in December 2016 from Calipatria State Prison (CAL) to drill down and obtain specific referral information. <i>Included in monthly Coleman Court package.</i>	HEART	Monthly and On Demand via HEART
MHCB Referrals	Detailed report regarding the number of MHCB referrals received by institution. User enters desired parameters for month, year, and referral disposition. User can click on a number (e.g., number of referrals in December 2016 from CAL) to drill down and obtain specific referral information.	HEART	On Demand via HEART

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPOP)
Description of Distributed Reports (July 2017)

ATTACHMENT C

OUTPATIENT TRANSPORTATION SCHEDULING REPORTS & WAIT LISTS

Report Name	Description	Data Source	Distribution Frequency
OUTPATIENT TRANSPORTATION SCHEDULING REPORTS			
Health Care Transportation Scheduling Priorities	Direction to Division of Adult Institutions (DAI)/Transportation Services Unit staff regarding health care placement/transfer priorities and limitations for the following week.	HCPOP	Weekly
EOP Chart for HCPOP CSRs	Chart showing percent of capacity by EOP program. Used to facilitate endorsement decisions.	HCPOP	Weekly
Friday "Do's and Don'ts" Meeting Chart	Chart showing intake and percent of capacity by institution. Used for discussion with Mental Health Regional Administrators whether to open or close an institution to intake the following week.	HCPOP	Weekly
Weekly EOP Population Report (aka Sum chart)	Summary of EOP census and vacancies by EOP institution. Includes total bus seats requested and bus seats provided for the following week. Used to facilitate transportation scheduling, projections, bed planning, and population trending.	HCPOP DAI Population Management Unit (PMU)	Weekly
CCCMS Housing – Destination Facility	Details CCCMS bus seats requested but not moved by level, type, and receiving institution. Used to facilitate transportation scheduling.	HCPOP DAI PMU	Weekly
CCCMS Potential Additional Intake	Reports the number of specific CCCMS spaces available by institution based on 100% and 130% of operational capacity. Used to facilitate transportation scheduling.	HCPOP DAI PMU	Weekly
EOP Bus Seat Summary	Chart showing EOP bus seats requested and provided by institution.	HCPOP; DAI PMU	Weekly
OUTPATIENT WAIT LISTS			
PSU Wait List	Report of EOP/SHU inmates waiting for a PSU bed. <ul style="list-style-type: none"> Pending List = within 60 days of endorsement. Waiting List = greater than 60 days of endorsement. <i>Included in monthly Coleman Court package.</i> 	HCPOP	Weekly
ASU-EOP Hub Wait List	Report of ASU-EOP hub inmates pending transfer to a bed. <ul style="list-style-type: none"> Pending List = within 30 days from initial placement into ASU, or from clinical determination requiring EOP level of care. Waiting List = greater than 30 days. 	HCPOP	Weekly

REFERRALS TO INPATIENT PROGRAMS (RIPA) REPORTS

Report Name	Description	Data Source	Distribution Frequency
Census and Pending List Report	RIPA Report of capacity, census, and pending transfer by inpatient program. Census is broken down by Levels I-IV. Pending List is broken down into the various phases of a pending referral. <i>Numbers from this report are provided to the Coleman Court on a monthly basis.</i>	RIPA	On Demand via RIPA
Referrals Report	RIPA Report of number of referrals received by month and institution. User enters desired parameters for month, year, and referral type. User can click on a number (e.g., number of referrals in June 2016 from California Medical Facility) to drill down and obtain specific referral information.	RIPA	On Demand via RIPA

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPOP)
Description of Distributed Reports (July 2017)

ATTACHMENT C

Inpatient Program Discharge Report	RIPA Report detailing referrals that were physically discharged within the parameters entered by the user. User enters desired parameters for physical discharge date range and inpatient program(s).	RIPA	On Demand via RIPA
Inpatient Program Length of Stay Report	RIPA Report detailing length of stay for referrals that are within the parameters entered by the user. User enters desired parameters for admission and discharge date ranges and inpatient program(s).	RIPA	On Demand via RIPA
Out of Least Restrictive Housing (LRH) Report	Report of inmate-patients in psychiatric inpatient programs that are out of LRH as determined by HCPOP CSRs.	RIPA	On Demand via RIPA
Psychiatric Inpatient Programs Census and Waitlist Report	Court-ordered census report produced from the RIPA Census and Pending List Report as of the last Monday of each month. <i>Included in monthly Coleman Court package.</i>	RIPA	Monthly
Program Guide Compliance Report	Court-ordered monthly compliance report produced from data in RIPA. Details all Acute and Intermediate referrals that were admitted or closed and were not in compliance with the Program Guide transfer timeframes. Also includes details regarding rescinded and rejected referrals. <i>Included in monthly Coleman Court package.</i>	RIPA	Monthly

MEDICAL REPORTS

Report Name	Description	Data Source	Distribution Frequency
SOMS HCPOP Referrals and MHCB California Department of State Hospitals (DSH) Redirects	List of inmates that need a HCPOP CSR endorsement to an SOP bed or a redirect from DSH or MHCB to another institution.	SOMS	Daily
HCPOP Medical Classification Matrix	Matrix identifying all medical classification factors by institution levels.	SOMS	Weekly
Specialized Medical Beds Vacancy/ Redline Report	A SOMS Report that can be filtered by "Primary Use of Bed" and "Bed Status." Individual reports can be run for vacant beds and redlined beds. The Redlined Beds report is distributed with the Medical MIS Report for CTC and OHU beds with a Bed Status of "Not in Service."	SOMS	Weekly
Transfer Status of Cocci Restricted Inmates	Tracks, monitors, and facilitates the transfer of inmates identified as being susceptible to Cocci from institutions located in the hyper endemic area.	QM Cocci Registry	Weekly
Mule Creek State Prison (MCSP) Infill Project Census Report	Report of MCSP capacity and weekly census changes in facilities D and E by mental health code, medical risk designation, and Armstrong. <i>This report is provided directly to the Receiver.</i>	SOMS Reporting	Weekly
California Health Care Facility (CHCF) Census Report	Report of CHCF capacity and weekly census changes by facility.	SOMS Reporting	Weekly
Hemodialysis Census Report	Census of inmate-patients by institution currently receiving dialysis.	SOMS Reporting	Monthly

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPOP)
Description of Distributed Reports (July 2017)

ATTACHMENT C

MENTAL HEALTH TREND REPORTS

Report Name	Description	Data Source	Distribution Frequency
Mental Health Population Trends	Average total mental health population by level of care from 2008 to current. Includes mental health population as a percentage of the total CDCR in-state population by year. Based on weekly data averaged for the month.	HCPOP	Monthly
Psychiatric Inpatient Programs Trends (Acute / Intermediate Level of Care)	Statewide census, pending list, and timeframe averages by program. Based on weekly data averaged for the month. <i>Included in monthly Coleman Court package.</i>	HCPOP	Monthly
MHCB Trends	MHCB census by month and institution, and statewide pending list/wait list averages. Based on weekly data averaged for the month.	HCPOP	Monthly
Percentage of Total MHCB Referrals by Institution	Percentage of MHCB referrals by institution for each month.	HCPOP	Monthly
Statewide MHCB Referrals to HCPop: 2011-2017	Chart of monthly MHCB referrals totals by month since 2011.	HCPOP	Monthly
Statewide MHCB Referrals: Average Hours to Disposition	Number of MHCB referrals and average hours to disposition by disposition for the last six months. Dispositions include transferred, internally admitted, and rescinded cases.	HCPOP	Monthly
PSU Trends	Average census, pending list, and movement trends for PSU cases. Breaks down endorsed cases moved versus not moved. Based on weekly data averaged for the month.	HCPOP	Monthly
ASU-EOP Hub Trends	Average ASU-EOP census trends by hub and total non-hub. Based on weekly data averaged for the month. <i>Included in monthly Coleman Court package.</i>	HCPOP	Monthly
EOP Trends	Statewide census and pending list averages by EOP program. Based on weekly data averaged for the month.	HCPOP	Monthly
EOP Movement Trends	Trends for endorsed cases that are moved vs. pending for Mainline to EOP, RC to EOP, and Total EOP. Based on weekly data averaged for the month.	HCPOP	Monthly
CCCMS Movement Trends	Trends for endorsed cases that are moved vs. pending for Mainline to CCCMS, RC to CCCMS, and Total CCCMS. Based on weekly data averaged for the month.	HCPOP	Monthly
Condemned Inmate Population	Pie chart displaying percentages of condemned inmates by mental health level of care.	HCPOP	Monthly

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
HEALTH CARE PLACEMENT OVERSIGHT PROGRAM (HCPOP)
Description of Distributed Reports (July 2017)

ATTACHMENT C

MEDICAL TREND REPORTS

Report Name	Description	Data Source	Distribution Frequency
Male CTC Trends for Medical Beds	CTC census by month and institution, and statewide wait list averages. Based on weekly data averaged for the month.	HCPOP	Monthly
Male OHU Trends	OHU census by month and institution, and statewide wait list averages. Based on weekly data averaged for the month.	HCPOP	Monthly
Female Specialized Medical Beds (SMB) Trends	Female SMB census by month and institution. Based on weekly data averaged for the month.	HCPOP	Monthly

MENTAL HEALTH PROJECTIONS

Report Name	Description	Data Source	Distribution Frequency
MHSDS Bed Need Study – Spring 2017 Projections	Projections for Mental Health bed need based on the Spring 2017 Office of Research Institution Population Projections.	HCPOP & McManis Consulting	Semi-annual

California Department of Corrections and Rehabilitation
 California Correctional Health Care Services
 Health Care Placement Oversight Program (HCPOP)

Classification Services Representative(CSR)/Correctional Counselor III

ACTIVITY TASK	PROJECTED ONGOING WORKLOAD		
	HOURS TO COMPLETE TASK	NUMBER OF TASKS PER YEAR	NUMBER OF HOURS PER YEAR
Specific Task			
Endorse inmates into a DSH facility after performing a complete file review to include, but not limited to: custody history and placement; escape risk; medical status; sentencing data and term; assaultive behavior; warrants and holds; cell status, and sensitivite needs.	2.00	4,698	9396.00
Endorse inmates discharged from DSH to an institution commeserate with the inmate's MH level of care and custody designation after performing a complete file review to include, but is not limited to: custody history and placement; escape risk; medical status; MH level of care; sentencing data and term; assaultive behavior; warrants and holds; cell status, and sensitivite needs.	1.25	783	978.75
Provide highly-skilled technical expertise to institutions, CDCR headquarters, and DSH staff regarding inmate placements.	1.00	52	52.00
Monitor the implementation of policies to ensure compliance with established timeframes for providing inmate access to DSH.	1.00	96	96.00
Maintain waiting lists and track inmate placements into and out of the DSH program, bed moves, and program changes.	1.00	261	261.00
Serve as subject matter expert for DSH placements and provide training to institutions and CDC headquarters staff.	6.00	6	36.00
Analyze administrative problems related to the program implementation and recommend effective action.	1.00	24	24.00
Enter data into the RIPA program.	1.00	261	261.00
Submit status reports on a weekly/monthly basis.	1.00	64	64.00
Participate in CCAT conference calls.	1.00	104	104.00
Enter data into the CERNER data base.	1.00	261	261.00
Supervise the CCII.	1.00	12	12.00
Maintain desk procedures.	8.00	1	8.00
Participate in mandatory peace officer training.	40.00	1	40.00
Participate in staff meetings and health care related in-service training.	1.00	24	24.00
TOTAL HOURS PROJECTED ANNUALLY			11,617.75
TOTAL POSITIONS PROJECTED			5.59

MENTAL HEALTH POPULATION PROJECTION UNIT IN THE OFFICE OF RESEARCH

PROPOSED OFFICE OF RESEARCH MENTAL HEALTH POPULATION PROJECTIONS STAFFING

Positions Requested

- 1 Research Manager II (RM II)
- 1 Research Specialist II (RS II)
- 2 Research Program Specialist II (RPS II)
- 1 Research Program Specialist I (RPS I)
- 1 Research Analyst I/II
- 1 Office Technician (OT)
- 1 Staff Information Systems Analyst (SISA)
- 1 Senior Programmer Analyst (SrPA)

Job Duties

Research Manager II - reporting to existing Office of Research Chief. The RMII manages the functions of the Mental Health Population Projections Unit and supervises staff engaged in the preparation of California Department of Corrections and Rehabilitation's (CDCR's) mental health population projections. The RM II develops and monitors mental health population projections assignment schedules; assigns, reviews, and edits work products; ensures assignment and process documentation is organized, accurate, and current; responds to inquiries from various stakeholders regarding CDCR's mental health population projections; leads and directs the preparation, quality control functions, and presentation of specialized mental health population impact estimates, reports, and analyses requested by various stakeholders, including CDCR executive management, Department Divisions and Offices, the Governor's Office, the Department of Finance and other State departments, the Legislature, Constitutional Offices, law enforcement agencies, district attorneys, courts, probation departments, advocacy associations, the media, parties involved in correctional litigation, and the public.

Research Specialist II - reporting to existing Office of Research Chief. The RS II acts as the liaison and technical advisor between the Mental Health Population Projections Unit and the existing Office of Research Population Projections and Estimates Unit to ensure that processes, procedures, methodologies, and timelines of projections and estimates are synchronized; collaborates with outside agency/consultants as needed in the development and validation of the mental health projections model. The RS II consults with the Chief/projections principal technical advisor to appropriately incorporate policy changes into mental health population projections and estimates models.

Research Program Specialist II [two positions] - reporting to new RM II. The RPS II develops, tests, and maintains the mental health population projections models, including the incorporation of emerging laws, propositions, policies, and programs that may affect the CDCR mental health

**MENTAL HEALTH POPULATION PROJECTION UNIT IN THE OFFICE OF
RESEARCH**

population; collaborates with others as needed in the development and validation of the projections model; trains staff on how to use the operational model to prepare forecasts related to the CDCR mental health population; keeps current on developments in correctional and mental health research, policy, and legislation, and their potential application to the CDCR mental health population; prepares and reviews reports and analyses on the CDCR mental health population.

Research Program Specialist I - reporting to new RM II. The RPS I analyzes and monitors trends in the CDCR mental health population; prepares forecasts of the CDCR mental health population that support the department's regular planning and operations; keeps current on developments in correctional and mental health research, policy, and legislation, and their potential application to the CDCR mental health population; prepares reports, tables, and figures to present CDCR mental health population projections.

Research Analyst I/II - reporting to new RM II. The RA I/II assists in the analysis and monitoring of trends in the CDCR mental health population; prepares standardized reports related to the CDCR mental health population; prepares reports, tables, and figures to present CDCR mental health population projections.

Office Technician - reporting to reporting to new RM II. The OT provides secretarial and clerical support for the Mental Health Population Projections Unit. The OT maintains schedules; prepares correspondence and memorandums; reviews reports; tracks assignments; and schedules meetings.

Staff Information Systems Analyst - reporting through an existing Office of Research Chief. The SISA is responsible for providing a wide range of technical assistance to the Mental Health Population Projections Unit. This position serves as backup to the Senior Programmer Analyst in documenting and providing ongoing maintenance and support of the Mental Health Population Projections Data Warehouse. The SISA works on complex information technology systems problems, and serves as the technical specialist performing complex analytical studies and activities on complex information technology systems, projects, and/or teleprocessing networks/systems.

Senior Programmer Analyst - reporting to existing Office of Research Associate Director. The SrPA serves as the primary information technology lead and subject matter expert in the development, documentation and ongoing maintenance of the Mental Health Population Projections Data Warehouse. The SrPA works on the most complex information technology systems problems, and serves as the advanced technical specialist performing complex coding and error correction activities. This position is responsible for working directly with Mental Health Projections Unit staff to provide technical direction and expertise to plan, develop, implement, operate, and maintain mental health population projections coding and software, including developing data processing standards and procedures.

**MENTAL HEALTH POPULATION PROJECTION UNIT IN THE OFFICE OF
RESEARCH**

Mental Health Population Projection Unit

Staff Information Systems Analyst Workload Analysis

ACTIVITIES & TASKS	PROJECTED ONGOING WORKLOAD			
	Hours Required to Accomplish	Frequency of Task (Monthly)	Months	Total Hours (Annually)
Provides technical assistance to the Mental Health Population Projections Unit	4	8	12	384
Serves as backup to the Senior Programmer Analyst in documenting and providing ongoing maintenance and support of the Mental Health Population Projections Data Warehouse	18	2	12	432
Builds, modifies, and maintains complex information technology systems problems related to mental health population projections and estimates	12	3	12	432
Serves as the technical specialist performing complex analytical studies and activities on complex information technology systems, projects, and/or teleprocessing networks/systems	12	5	8	480
Other responsibilities as needed	2	2	12	48
TOTAL HOURS PROJECTED ANNUALLY				1,776
TOTAL NUMBER OF STAFF INFORMATION SYSTEMS ANALYST POSITIONS REQUESTED				1